Shoe Medical Necessity Form

To the shoe provider: You must attach a completed Shoe Medical Necessity Form to all claims for shoes and shoe accessories. Claims with incomplete or missing forms will be denied. Please fill out Sections 1 and 2 of this form, and submit it with your written foot evaluation to the prescriber.

To the prescriber: Please review the shoe provider's written foot evaluation, complete Section 3 of this form, and return the completed form to the shoe provider. Important: Please keep a copy of the completed form and foot evaluation in the member's medical record.

Section 1: Member Information

Member name: _____ MassHealth ID no.: _____

Address: _____

SECTION 2 MUST BE COMPLETED BY THE SHOE PROVIDER.

Section 2: Shoe Provider.

Shoe provider name: _____ Tel. no.: _____

Address: _____ Provider no.: _____

Describe the shoes and shoe accessories to be prepared for this member:

_____

_____

Complete the following for each shoe and shoe accessory:

Manufacturer's name	Manufacturer's model number	Supplier's submitted charge	Supplier's invoice charge	MassHealth service code

I certify that the information I have completed on this form is true, accurate, and complete. I further certify that I have chosen the least costly method to provide medically necessary[1] shoes and shoe accessories. I understand that any falsification, omission, or concealment of material fact on this form may subject me to civil or criminal liability. ([1] See 130 CMR 450.204.)

Shoe provider's signature: _____ Date: _____

continued ▶

SECTION 3 MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER.

Section 3: Prescription.

Prescriber's name: _____ Tel. no.: _____

Address: _____ Provider no.: _____

Primary diagnosis: _____

Secondary diagnosis (Enter n/a if not related to items requested.): _____

I currently treat this patient for: ☐ Primary diagnosis ☐ Secondary diagnosis ☐ Both

The following items are medically necessary.

☐ Shoes

☐ Off-the-shelf moldable shoes	☐ right foot	☐ left foot	☐ both feet
☐ Off-the-shelf medical-grade oxford shoes	☐ right foot	☐ left foot	☐ both feet
☐ Off-the-shelf medical-grade oxford shoes, depth or hightop	☐ right foot	☐ left foot	☐ both feet
☐ Off-the-shelf surgical boots	☐ right foot	☐ left foot	☐ both feet
☐ Custom-molded shoes	☐ right foot	☐ left foot	☐ both feet

☐ Other (Specify — use attachment if necessary.): _____

☐ Internal Shoe Modifications

☐ Insert, customized	☐ right foot	☐ left foot	☐ both feet
☐ Insert, molded to foot	☐ right foot	☐ left foot	☐ both feet
☐ Arch support	☐ right foot	☐ left foot	☐ both feet
☐ Lift inside shoes	☐ right foot	☐ left foot	☐ both feet

☐ Other (Specify — use attachment if necessary.): _____

☐ External Shoe Modifications

☐ Sole or heel wedge	☐ right foot	☐ left foot	☐ both feet
☐ Sole or heel	☐ right foot	☐ left foot	☐ both feet
☐ Rigid rocker bottom	☐ right foot	☐ left foot	☐ both feet
☐ Roller bottom	☐ right foot	☐ left foot	☐ both feet
☐ Lift outside shoes	☐ right foot	☐ left foot	☐ both feet

☐ Other (Specify — use attachment if necessary.): _____

I certify that I am the treating prescriber identified on this form, and that I have reviewed the description of service and cost (Section 2), which has been certified by the shoe provider. I attest that the items described in Section 2 of this form fulfill the requirements of my prescription. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the information on this form, specifically including medical- necessity[1] information, is true, accurate, and complete. I understand that any falsification, omission, or concealment of material fact on this form may subject me to civil or criminal liability. ([1] See 130 CMR 450.204.)

Prescriber's signature and credentials (MD, NP, DO, or DPM): _____ Date: _____

(Signature and date stamps are not acceptable.)